std/aids control

annual report 2003

STD / AIDS control annual report 2003

BC Centre for Disease Control

Excellence Program

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std/aids control

The British Columbia Centre for Disease Control is an organization dedicated to the prevention and control of communicable diseases in British Columbia.

The Division of STD/AIDS Control is exclusively focused on the prevention and control of sexually-transmitted diseases (STIs), including HIV and AIDS.

Located in Vancouver, our activities fall into four main areas:

- We coordinate province-wide efforts to reduce the spread and minimize the adverse effects of STIs. We do this through education programs, contact tracing and partner notification. The division works with clients both directly, through clinics and outreach workers, and indirectly through local and regional health care providers. The health, dignity and rights of our clients are our foremost concern.
- We provide STI/AIDS-related education and training resources for health care workers throughout the province, including medical residents, interns, public health nurses and other health care providers. We participate in conferences and frequently present on STI-related subjects, both in B.C. and in other jurisdictions.
- We provide epidemiologic data analysis and consulting services, acting as the provincial reporting centre for cases of STIs, HIV and AIDS. Provincial law requires most STIs including HIV be reported so that trends and patterns can be accurately measured. Our role is to record, track and share this important data for the benefit of provincial health care authorities, as well as authorities in other jurisdictions, including international organizations and governments.
- We participate in STI/AIDS related research and teaching as a university affiliated organization, helping us remain current in our approach.
- We work with international partners in developing countries to improve their capacity to manage STIs and HIV.

This annual report describes some of the objectives, activities and achievements that marked the past year at STD/AIDS Control. It also includes detailed epidemiology statistics. More information on many of the subjects discussed here can be found on our website at www.bccdc.org, or through our Resource Centre at 604-660-2090.

director's letter

Dr. Michael Rekart, Director

A Message from the Director

2003 was a pivotal year for the STD/AIDS Control Program. In May, British Columbia became the last province in Canada to make HIV a reportable disease. This important move forward generated a whole new set of rewards and challenges including new training strategies for patient counselling and contact follow-up, the initiation of a process and outcome evaluation of HIV reportability and a closer working relationship between BCCDC and the Health Authorities.

In 2003, the division established a Research Program and welcomed Darlene Taylor as Research Coordinator. Since then, our research efforts have grown considerably. Dr. Gina Ogilvie also joined us as Associate Director in 2003 and she has greatly enhanced the breadth and depth of our expertise, especially regarding reproductive health and human papillomavirus issues. This marked the final year in the tenure of Ron Zapp as BCCDC's leader. Ron was a strong supporter of STD/AIDS Control and we wish him well during his retirement. STD Control also said good-bye and good luck to our long-serving surveillance analyst, Rob MacDougall, although we continued to draw on Rob's expertise from his new position in the Provincial Laboratory.

Most importantly, we continued to deliver the same high quality programs and we supported our patients and one another.

Michael L. Rekart

Dr. Michael Rekart
Director, STD/AIDS Control

the year in review

Clinical Activities

Chee Mamuk Program

Education and Communications

Projects Funded

Publications/Conference Proceedings/ Conference Abstracts/Presentations

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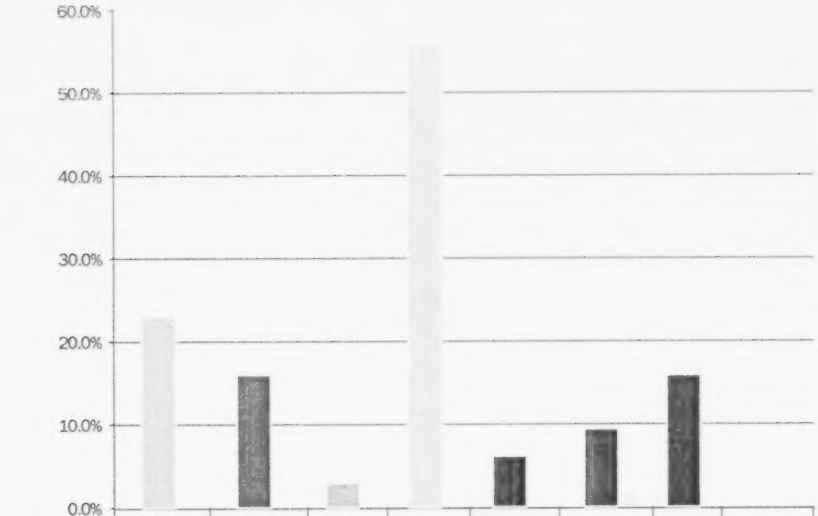
clinical activities

STD Clinic and Street Nurses

The division's patient services are delivered through two principal channels: the STD Clinic, located in the BCCDC building at 655 West 12th Avenue in Vancouver, and the Street Nurse Program, which operates from a number of locations throughout the city.

1.1 Reason For Visit • 2003



	STD Screening	STD Symptoms	Contact to STD	HIV Testing	Hepatitis	Wart Treatment	Other*	# Visits
Percentage	23.0	16.0	3.0	55.9	6.1	9.2	15.8	100.0
Number	3,904	2,714	504	9,502	1,043	1,558	2,692	17,008

* *Other includes: Birth control, counselling, consultation, follow-up, immigration, pregnancy test, results, TB skin testing, treatment and test of cure.*

Note: Percentages do not equal 100% because one client may have several reasons for visit (e.g. HIV testing, symptoms and STI screening).

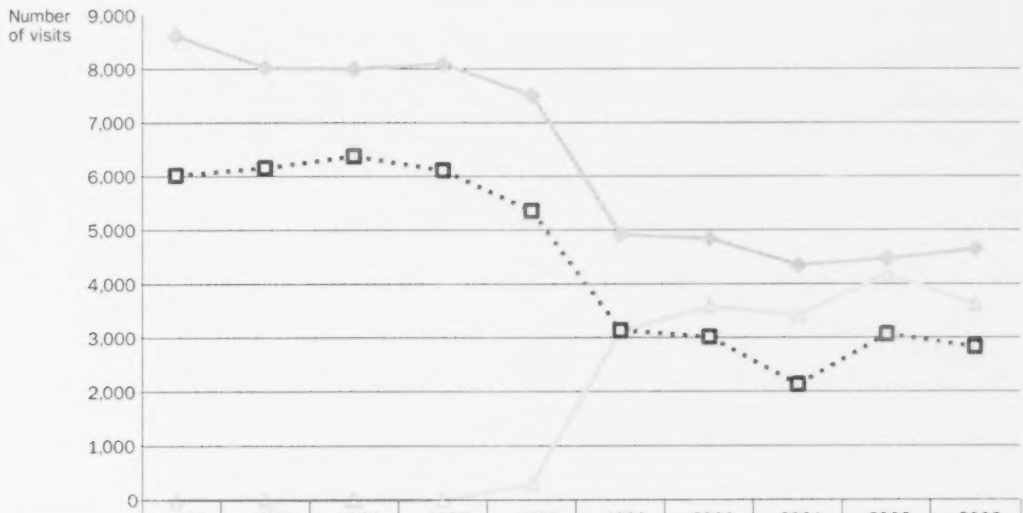
In 2003 the STD Clinic and Street Nurse Program recorded 17,008 visits. As in previous years, slightly more than half of these visits (9,502 or 55.9%) included some aspect of HIV testing as a reason for visiting. Hepatitis testing or vaccination was the reason for 6.1% (1,043) of visits. Just over half of the visits (8,680 or 51%) were for reasons related to STI. STI screening was the reason for 3,904, or 23%, of visits. An STI symptom was the reason for 2,714, or 16%, of visits. Contact to STI was the reason for 504, or 3%, of visits and genital wart treatment was the reason for 1,558, or 9.2%, of visits. Reasons for visit numbers for 2003 are similar to previous years, with a slight increase in visits for STI screening and genital wart treatment and a small decrease in visits related to hepatitis.

west 12th std clinic

The STD Clinic on 12th Avenue is centrally located, easily accessible to clients, close to the downtown core and adjacent to Vancouver General Hospital. As the site of our primary clinical facility, it provides STI assessment and management services, including HIV testing, for clients from throughout the Lower Mainland. In addition, it is the centre of our epidemiology, education, research and administration activities. At this location we also:

- Conduct STD/HIV/AIDS surveillance, reporting, data management and related epidemiology services.
- Conduct and co-ordinate ongoing STD/HIV/AIDS research at our own and affiliated facilities.
- Provide training in STI clinical management for health care workers from across the province.
- Operate the province-wide STD/AIDS information phone line.
- Operate partner notification services.
- Maintain an STI/AIDS education resource centre for province-wide use.
- Provide administration of all division operations.

1.2 West 12th STD Clinic Visits • 1994 to 2003



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
STD	8,616	8,022	8,004	8,093	7,503	4,915	4,837	4,349	4,460	4,642
HIV	6,018	6,154	6,368	6,108	5,349	3,133	3,007	2,128	3,063	2,822
STD & HIV	0	0	0	0	285	3,110	3,589	3,412	4,176	3,620
Total	14,634	14,176	14,372	14,201	13,137	11,158	11,433	9,889	11,699	11,084

street nurse program (std/aids outreach)

The AIDS Prevention Street Nurse Program (SNP) is the outreach nursing-based program of the STD/AIDS Division. The focus of the SNP is STI/HIV prevention in the at-risk, hard to reach and marginalized populations. There were 39,646 client encounters in 2003.

Working collaboratively with a wide range of partners, the SNP operates in the framework of prevention, harm reduction, health promotion and population health to develop innovative and responsive STI/HIV prevention initiatives. Strategies such as social networking are being used to address the syphilis outbreak in the downtown eastside (DTES).

Service delivery: STI/HIV testing, diagnosis and treatment, follow-up and referrals are provided in both clinical and non clinical settings.

- **Bute St. Clinic** – Located in "the Centre", the lesbian, gay, bisexual and transgendered community centre, Bute Street Clinic continues as a busy site with 5269 client encounters in 2003. A nurse at the clinic provides regular outreach to bathhouses in order to reach gay men.
- **Clinical services** – Offered at small sites housed in Pender Community Health Clinic (PCHC), BC Corrections for Women (BCCW), Vancouver Detox, and Seymour Street Youth Services site.
- **Mobile clinics/services** – Include Youth Action Centre (YAC), Women's Information Safe House (WISH), Dusk to Dawn, hotels, strolls, parks, health fairs and others sites as needed.

Education programs: Education programs for client groups, community groups and peer education programs are provided locally, provincially and internationally. Workshops and field experiences are offered for health professionals and university and college students.

- **SNP partnered with Chee Mamuk** (STI/AIDS aboriginal program) to provide several STI/HIV workshops on reserves throughout British Columbia.
- **SNP partnered to provide peer education programs:** for drug users in Surrey, with Family Services Peer Education Program for Youth and with BC Multicultural Society for the Hepatitis C Peer Education Project.
- **Workshops:** Fraser Valley University, University of British Columbia and Langara College.
- **Province-wide public forums** in connection with the film "FIX."

Innovative projects: New projects are incorporated into programming.

- **Health Fairs** – Four youth health fairs and two DTES health fairs were held as a collaborative community initiative. A manual, "How to organize a health fair in your community," was produced and distributed.
- **Peer Project** – Two peers (those who have been street-involved) were hired on contract to work with the SNP in the social networking initiative.
- **Massage parlour outreach** – Street nurses worked with peers to access workers in massage parlours.
- **Supervised injection site** – Worked in collaboration with Vancouver Coastal Health Authority to develop policy and procedures for nursing.
- **Papalooza** – Pap testing and sexually transmitted disease testing were done at festive Papalooza events in April and October to try to reach women who are not accessing pap testing.

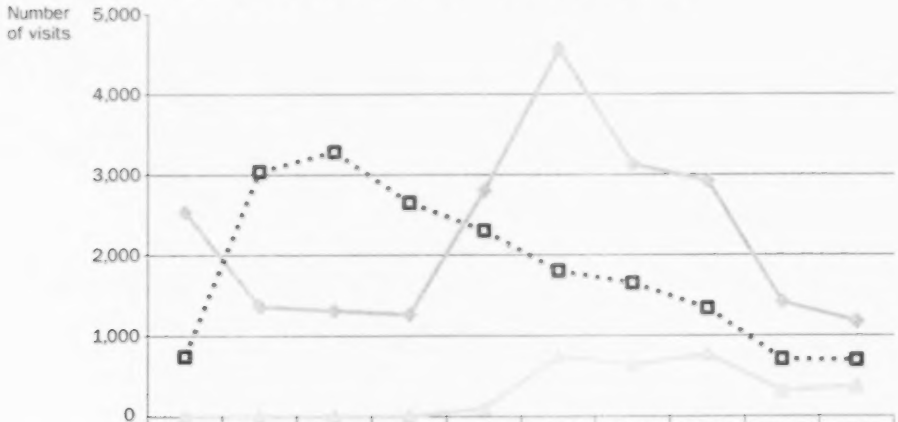
Research

- **Health Canada Street Youth Study** – SNP participated in the Vancouver portion of study interviewing/testing 300 street-involved youth.
- **Sex Now Survey** – SNP collaborated with community partners to conduct surveys in Vancouver, Victoria and Prince George at Pride events.

1.3 Bute Street Clinic Visits • 1994 to 2003

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
STD	945	689	843	729	1,923	1,081	985	849	869	1,132
HIV	289	1,444	1,478	1,336	1,487	1,137	1,197	1,062	1,282	1,257
STD & HIV	0	0	0	0	23	326	396	358	566	592
Total	1,234	2,133	2,321	2,065	3,433	2,544	2,578	2,269	2,717	2,981

1.4 Agency Outreach Visits • 1994 to 2003



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
STD	2,540	1,364	1,311	1,265	2,804	4,563	3,126	2,920	1,415	1,175
HIV	740	3,033	3,278	2,646	2,297	1,801	1,646	1,335	704	689
STD & HIV	0	0	0	1	101	747	639	765	319	372
Total	3,280	4,397	4,589	3,912	5,202	7,111	5,411	5,020	2,438	2,236

the Chee Mamuk program

Chee Mamuk:

- A provincial aboriginal education program.
- Mandated to provide culturally appropriate on-site community-based HIV/AIDS and STI education training.
- Works with aboriginal communities, organizations and professionals within BC.

Second National Aboriginal Hepatitis C Conference, Richmond, BC, May 4-7, 2003

Chee Mamuk was handed the responsibility of hosting the Second National Aboriginal Conference at a ceremony during the first national conference in Edmonton. Aboriginal and hepatitis C organizations partnered to plan the 2003 conference.

Conference Participant Comments:

"Everyone has a responsibility to educate their family and community."

"Honor, respect and love for each other and amongst our people. Information, knowledge is power. Culture is treatment."

"The organization of the conference was well done."

"Confirmed how important culture, spirituality, community, teamwork and resourcefulness are. Thanks. You all did a wonderful job."

"Gaining a better insight into the importance and impact of aboriginal culture and spirituality for health."

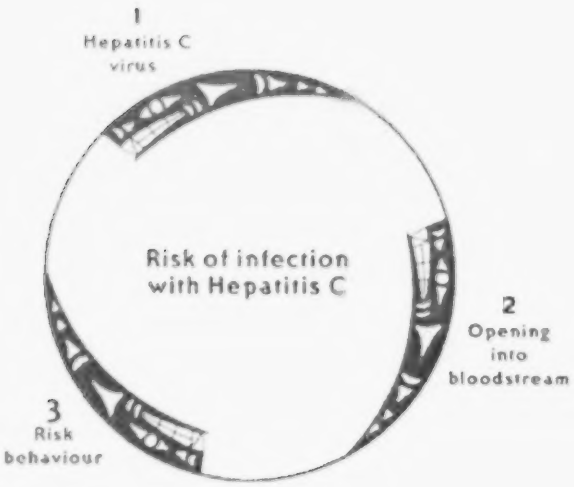
Conference theme:

"Weaving Mind, Body and Spirit" addressed the need to provide holistic, culturally relevant hepatitis C virus (HCV) education and support.

The conference celebrated:

Creation of a national May 1st Aboriginal Hepatitis Awareness Day.

- Tri-lateral declaration for the day was supported by the Metis National Council, the Inuit Tapiritt Kanatami and the Assembly of First Nations.
- A sunrise ceremony was held in Crab Tree Park, Vancouver to announce and witness the first Aboriginal Hepatitis Awareness Day.



The 240 Conference delegates included:

- Direct health service providers.
- Aboriginal peoples, communities and organizations.
- Aboriginal people with HCV.
- Injection drug users.
- Elders and youth.
- Funding agencies and other supporters.

The Conference workshop and panel topics included:

- Prevention, harm reduction, youth, addictions, treatment, women, co-infection, research, residential school issues, self care, prisons, living with hepatitis C (individual and family) and more.

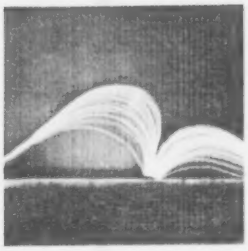
The Third National Aboriginal Hepatitis C Conference will be hosted by All Nations Hope in May 2005 in Regina.

education and communication: meeting new challenges

- Collaboration with the Registered Nurses' Association of BC (RNABC) to design and develop a Nursing Practice Competency Framework that would position STD Control to respond to the 'reserved act' issues in the pending Provincial Registered Nurses scope of practice legislation.
- Collaboration with the Community Based Research Network, to support the design and rollout of a provincial prevention project focused on gay men's health. The "SEX NOW: by the numbers" survey is a compilation and analysis of feedback from 1900 men from three provincial locations. The findings of this initiative were published and distributed.
- Completion of the research project evaluating primary care physician STI/HIV counselling practices. This was a cross-sectional survey conducted to determine current counselling and testing practices of primary care physicians in British Columbia regarding HIV and STIs. Physicians were asked if they used the STD Guidelines and, if so, how they interpreted the guidelines in their practice. Publication is pending in the B.C. Medical Journal and Canadian Medical Association Journal.

projects funded

Health Service Delivery Area	City	Project Description
Interior Health Authority – Kootenay Boundary Health Service Delivery Area	Grand Forks	Sexual Health for Male Youth. A contractor will be hired to work with 4 - 6 youth male peer leaders. They will be given sexual health training and develop sexual health resources for male youth.
Vancouver Island Health Authority – North	Parksville	Produce an instructional package and resources for communities to hold a Grade 9/10 health fair promoting sexual health.
Vancouver Coastal Health – North Shore/Coast Garibaldi	Powell River	Develop and Implement a region-wide "condomania" campaign targeted to 13-25 year old females.
Vancouver Island Health Authority – North (Comox Valley)	Campbell River	Chlamydia awareness raising. Identify coordinators, develop awareness raising plan that may include posters, ads, education materials, school participation, etc.
Vancouver Island Health Authority – North (Comox Valley)	Campbell River	Continuation of previous project working with the Reproductive Health Committee for school district 72 and C.R. Planned Parenthood. Increase awareness of STIs through established parent teacher committees.
Vancouver Island Health Authority – North (Mt. Waddington)	Campbell River	Revise, expand and re-implement the Peer Education Program established with the 2001 grant.
Northern Interior Health Authority	Quesnel	Increase chlamydia awareness through radio advertisement and provide education and support to physicians.
Vancouver Island Health Authority – Central	Duncan	Hold a conference on sexual health peer education programs for youth and adults in CVIHA. Conference would include keynote speakers and a STI/HIV update component.
Vancouver Island Health Authority – Central	Port Alberni	Partner with the Youth Health Centre to work with First Nations youth to decrease barriers to reproductive health care.
Vancouver Coastal Health Authority – North Shore/Coast Garibaldi	North Vancouver	Provide sexual health training to secondary school peer counsellors. Education will include risk behaviour, unwanted pregnancy, increased chlamydia rates, HIV/AIDS education and understanding what constitutes misinformation.
Interior Health Authority – East Kootenay	Creston	Development and implementation of a sex positive, holistic sexual health education experience for local grade 9 girls at a two day camp retreat.
Fraser Health Authority – Fraser Valley	Surrey	Provide HIV/AIDS education to health care workers, social service professionals and other community workers (target group 250 – 300)



publications/conference proceedings/ conference abstracts/presentations

Mike Rekart

Presentations

Eliminating bacterial STIs: We need new tactics, ISSTDR 2003.

BC's syphilis mass treatment intervention: An evaluation. ISSTDR 2003.

Publications

Jayaraman G. C, Gleeson T, Rekart M. L. et al **Prevalence and determinants of HIV-1 Subtypes in Canada: Enhancing Routinely Collected Information Through the Canadian HIV Strain and Drug Resistance Surveillance Program.** Can Commun Dis Rep 2003; 29(4): 29-36.

Pourbohloul B, Rekart ML, Brunham RC. **Impact of mass treatment on syphilis transmission: A mathematical modelling approach.** Sexually Transmitted Diseases, 2003; 30 (4): 297-305.

Rekart ML. **The Impact of HIV reporting on HIV pretest counselling.** BC Med Journ 2003; 45(3).

Rekart ML, Patrick DM, Chakraborty B, Maginley JLJ, Jones HD, Bajdik CD, Pourbohoul B, Brunham RC. **Targeted mass treatment for syphilis with oral azithromycin.** Lancet 2003; 361 (9354): 313-14.

Rekart ML, Rekart JT, Brunham RC. **International Health: Five Reasons Why Canadians should get involved.** Canadian Jounal of Public Health, 2003; 30 (4): 258-59.

Abstracts/Conference Proceedings

Jones HD, Knowles LK, Montgomery CA, Rekart ML, Morshed M, Hansen L, Csobot M, Taylor DL. **Oral Syphilis in BC: Case Presentations.** International Society for Sexually Transmitted Diseases Research. Ottawa, ON, July 27-30, 2003.

Jones HD, Knowles LK, Montgomery CA, Rekart ML, Morshed M, Hansen L, Csobot M, Taylor DL. **Oral Manifestations and Transmission of Primary and Secondary Syphilis.** International Society for Sexually Transmitted Diseases Research. Ottawa, ON, July 27-30, 2003.

Jones HD, Vipond J, Patrick DM, Rekart ML, Montgomery CA, Money DM, Taylor DL, Morshed M. **Syphilis: Pre-natal Screening and Pregnancy Outcome in British Columbia, Canada.** International Society for Sexually Transmitted Diseases Research. Ottawa, ON, July 27-30, 2003.

Jones HD, Willoughby B, Maguire J, Zwimpfer T, Morshed M, Rekart ML, Crawford R, Gul S, Montgomery CA. **Cerebral Syphilitic Gumma in an HIV Male confirmed using PCR technique.** International Society for Sexually Transmitted Diseases Research. Ottawa, ON, July 27-30, 2003.

Jones HD, Wong E, Hutchinson K, Rekart ML. **Only RPR Screening of High Risk Individuals: Is That Enough?** International Society for Sexually Transmitted Diseases Research. Ottawa, ON, July 27-30, 2003.

Montgomery CA, Jones HD, Knowles LK, White R, Wong E, Rekart ML, Taylor D. **Recurrent Non Gonococcal Urethritis (NGU): Rate reduced with Azithromycin to Treat the Initial Episode.** International Society for Sexually Transmitted Diseases Research. Ottawa, ON, July 27-30, 2003.

Rekart ML. **Interventions to Prevent and Eliminate Syphilis.** International Society for Sexually Transmitted Diseases Research. Ottawa, ON, July 27-30, 2003.

Wittenberg L, Brunt C, Hansen L, James L, Jones HD, Knowles LK, Maginley J, Montgomery CA, Rekart ML, Tigchelaar J, Wrath K. **Enhanced Contact Tracing for Syphilis Utilizing Social Networking Methods.** International Society for Sexually Transmitted Diseases Research. Ottawa, ON, July 27-30, 2003.

Gina Ogilvie

Presentations

Innovative Methods for Screening for Cancer in Marginalized Populations – HPV Self Sampling. BC Cancer Agency Annual Conference, November 2003.

Social Networking in Controlling Sexually Transmitted Diseases. Community Medicine Residency Program, October 2003.

Infectious Syphilis Thriving in BC. Department of Family Practice, VGH and UBCH, October 2003.

Impact of Self Sampling for HPV in Marginalized Women (Work in Progress). Department of Family Practice, UBC, September 2003.

Self Sampling for STIs. Division of STD/AIDS Control, BCCDC, June 2003.

Publications

Alimenti A, Burdge DR, Ogilvie GS, Money DM, Forbes C. **Lactic Acidemia in Infants Exposed to Perinatal Antiretroviral Therapy.** Ped Infect Dis J. 2003 Sep; 22(9): 782-9.

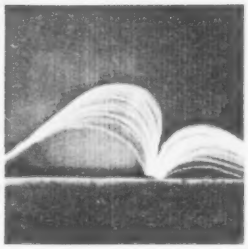
Abstracts and Conference Proceedings

Grzybowski S, Ogilvie GS. **The Bear (sic) Bones of Building Research Capacity.** Family Medicine Forum, October 2003, Calgary Alberta.

Knowles L, Ogilvie GS, Taylor D, Rekart M. **Outcomes of a Social Networking Approach (SNA) to Syphilis Case Finding in a Street Nurse Program: Improved Case Finding and Contact Identification.** Second International Conference on Urban Health, October 2003, New York, USA.

Ogilvie GS, Patrick DM, Sellors JS, Schulzer M, Petric M, Fitzgerald M. **Diagnostic Accuracy of Self Collected Cervicovaginal Samples for Human Papillomavirus vs Clinician Collected Samples: A Meta-Analysis.** ISSTDR, July 2003, Ottawa, Canada.

Tigchelaar J, Brunt C, James L, Knowles L, Taylor D, Jones H, Rekart M, Ogilvie GS. **Incorporating a Social Networking Approach (SNA) into a Street Nurse Program (SNP) to Enhance Contact Tracing in an Outbreak of Syphilis.** Second International Conference on Urban Health, October 2003, New York, USA.



publications/conference proceedings/ conference abstracts/presentations

Melanie Achen

Presentations

June 5/2003 - to the BC Association of Pregnancy Outreach Programs.

August 21/2003 - to the UBC Family Practice Residents (Year 2).

Hugh Jones

Presentations

Infectious Syphilis Thriving in BC. Department of Family Practice, VGH and UBCH, October 2003, Vancouver, B.C.

Infectious Syphilis Thriving in BC. Department of Family Practice, SPH, September 2003, Vancouver, B.C.

Abstracts and Conference Proceedings

Jones HD, Wong E, Wong Q, Hutchinson K, Rekart ML. **Only RPR Screening of High Risk Individuals...Is that enough?** ISSTDR, July 2003, Ottawa, Canada.

Jones HD, Vipond JCF, Patrick DM, Rekart ML, Montgomery CA, Money DM, Taylor DL, Morshed M. **Syphilis: Pre-Natal Screening and Pregnancy Outcome in British Columbia, Canada.** ISSTDR, July 2003, Ottawa, Canada.

Jones H, Knowles LK, Montgomery CA, Rekart ML, Morshed M, Hansen L, Csobot M, Taylor D. **Oral Syphilis: Case Presentations.** ISSTDR, July 2003, Ottawa, Canada.

Jones HD, Knowles L, Montgomery CA, Rekart ML, Morshed M, Hansen L, Csobot, M, Taylor DL. **Oral Manifestations and Transmission of Primary and Secondary Syphilis.** ISSTDR, July 2003, Ottawa, Canada.

Montgomery CA, Jones JD, Knowles LK, White R, Wong E, Rekart ML, Taylor D. **Recurrent Non-Gonococcal Urethritis (NGU): Rate Reduced with Azithromycin to Treat the Initial Episode.** ISSTDR, July 2003, Ottawa, Canada.

Wittenberg L, Brunt C, James L, Jones H, Knowles L, Maginley J, Montgomery C, Rekart ML, Tigchelaar J, Wrath K. **Enhanced Contact Tracing for Syphilis Utilizing Social Networking Methods.** ISSTDR, July 2003, Ottawa, Canada.

STD Outreach Staff

Abstracts and Conference Proceedings

Tigchelaar J, Brunt C, James L. **Using Peer Outreach Workers to Target Street Involved Polulations at High Risk for Contracting Syphilis.** ISSTDR, July 2003, Ottawa, Canada.

highlights of 2003

HIV Reportability

Associate Director

Research

annual report 2003

HIV reportability

HIV became a reportable disease in British Columbia on May 1, 2003. This action followed much discussion throughout the province and a thorough literature review of the impacts of partner notification for HIV. Prior to this, British Columbia was the only jurisdiction in Canada that did not routinely involve public health nursing in HIV partner notification.

Partners of HIV infected persons are at high risk for infection. Focusing on the high risk contacts to prevent transmission is a key strategy in reducing HIV epidemics. An active, supported partner notification and counselling system, using trained skilled professionals to help physicians and patients, can identify up to seven times more contacts than a passive system which relies on index patients.

The primary objective in making HIV reportable is to improve and facilitate partner counselling and referral which will potentially shorten the time from infection to diagnosis and treatment/counselling. Reportability also provides public health the opportunity to be directly involved with cases and thus improve case management. In addition, reportability will enhance epidemiological surveillance, especially at the local level, so that public health can respond appropriately to HIV/AIDS.

BCCDC STI/HIV nurses participate in all aspects of HIV reportability including:

- Assisting with defining and developing the process.
- Developing and maintaining forms used in the process.
- Arranging educational sessions for nurses working with HIV reportability.
- Providing a coordinating role in the process.
- Providing individual case consultation support.
- Coordinating the evaluation project.
- Maintaining communication with the assigned public health nurses through regularly scheduled conference calls.
- Advocating for resources.
- Providing access to ongoing educational sessions in Partner Counselling and Referral Services.

Each provincial health jurisdiction has at least one public health nurse responsible for case management of all new HIV infections.

The work of HIV reportability is not easy, but early reports of successes achieved by nurses makes it worth the effort. Although this new work is stretching limited resources, the public health nurses are very supportive. Public health nurses are identifying gaps in service that must be filled in order to support patients who have been newly diagnosed HIV positive. Overall, the first year of HIV reportability, we believe, has been a success.

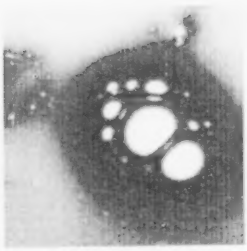
Dr. Gina Ogilvie, associate director

Dr. Gina Ogilvie joined STD/AIDS Division as Associate Director in May 2003. Dr. Ogilvie has a background in Family Medicine, Population Health and Clinical Epidemiology, and is also appointed to the Department of Family Practice at the University of British Columbia. Her clinical and research interests include innovations in the testing and treatment of sexually transmitted infections, human papillomavirus and improved STI/HIV care and access for women.

Dr. Ogilvie works closely with the Research Program, Chee Mamuk and the Street Nurse Program.

In 2003, Dr. Ogilvie was awarded a Canadian Institute of Health Research (CIHR) grant to study self sampling for human papillomavirus in marginalized women. This study will help to determine whether an innovative method of sampling for women can help to improve the uptake of cervical cancer screening in an at risk population. The collaborative team for this study includes the Street Nurse Program, BC Cancer Agency, the Department of Family Practice and community members. In addition, Dr. Ogilvie is conducting research in the reproductive health of HIV positive women and examining the antenatal seroprevalence of HIV and hepatitis C in British Columbia.

Dr. Ogilvie is also coordinating a provincial media campaign targeting the gay community to promote safe sex and sexual health practices.



Darlene Taylor, research program coordinator

Darlene Taylor was hired as the Research Program Coordinator for STD/AIDS Control in January 2003. She has a nursing background and is currently pursuing a Master's degree in Health Care and Epidemiology at the University of British Columbia.

The Research Program in STD/AIDS was formalized in January 2003 with the creation of a research plan. This plan was consistent with both BCCDC and STD/AIDS goals. A Research Committee was formed to review research proposals (internal and external) to determine the project's merit and whether the project assists STD/AIDS Control meet its divisional goals.

During 2003, we conducted six research studies:

- Population based chlamydia prevalence study
- Surveillance study of STI among street youth
- A rapid HIV test study
- A study of contraceptive choices in HIV positive women
- An evaluation of HIV reportability
- Social networking study.

A number of staff members have written abstracts and presented research findings at national and international conferences. Two posters on social networking were presented at the Canadian Association for HIV Research in New York, NY in October 2003. Nine staff members attended the International Society for Sexually Transmitted Disease Research (ISSDTR) in Ottawa in July 2003. Staff posters and oral presentation topics included:

- Diagnostic Accuracy of Self-obtained HPV Cervicovaginal Samples versus Clinician-obtained Samples: A Systematic Review
- Pre-natal Screening and Pregnancy Outcomes in British Columbia
- Enhanced Contact Tracing for Syphilis Utilizing Social Networking Methods
- Only RPR Screening of High Risk Individuals ... Is that enough?
- Oral Manifestations and Transmission of Primary and Secondary Syphilis
- Oral Syphilis: Case Presentation
- Recurrent Non-Gonococcal Urethritis (NGU): Rate Reduced with Azithromycin to Treat Initial Episode
- Connecting and Communicating with Street Involved Persons who are At-risk for Syphilis and other Sexually Transmitted Diseases
- Using Peer Outreach Workers to Target Street Involved Populations at High Risk for Contracting Syphilis
- Cerebral Syphilitic Gumma in an HIV Male Confirmed using PCR technique.

The research program at STD/AIDS Control has created a framework for research studies and this year's research forms the foundation for future endeavours.

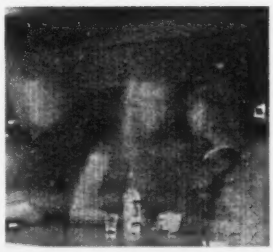
incident trends

The number of new AIDS cases for 2003 was 75. This is similar to 2001 (77) and 2002 (88). There were no significant trends according to gender, age, risk, ethnicity or geographic location.

There were 421 persons testing newly positive for HIV in 2003, a small decrease from 439 in 2002. There were no significant trends in age, gender, risk, ethnicity or geographic location of these cases. HIV was made a reportable disease in May 2003, entailing rigorous case and contact follow up at the local level. Because of delays in receiving full case reports, the 'unknown' categories for demographic characteristics were somewhat larger than in previous years. We expect to receive this data at a later date. It is important to note that the increase in HIV for MSM between 2000 to 2001 (from 96 to 134) has shown no further increases in 2003.

Syphilis however, continued to increase significantly. There were 263 cases in 2003 compared to 187 in 2002. The BC rate increased significantly from 4.5 to 6.3 per 100,000 (normal-value test, $p<0.01$). The Canadian rate also increased between 2002 and 2003, mirroring not only the BC situation but outbreaks in other jurisdictions as well. The epidemic in the gay community increased between the first half of 2003 (30 cases) to the second half (49 cases). This trend has continued and intensified into 2004. There are now clearly two syphilis outbreaks in BC: one within the gay male population and one associated with the heterosexual sex trade in Vancouver's downtown eastside. Although most of the 2003 provincial increase was in Vancouver, there were small increases in infectious syphilis cases in Richmond and North Shore/Coast Garibaldi. No significant trends occurred according to age or gender

The chlamydia rate also increased significantly from 183.6 per 100,000 in 2002 to 192.7 in 2003 (normal-value test, $p<0.01$). There were no important trends based on age, gender or geographic location of cases. This continues an upward trend in BC which began in 1997 (103.9 cases per 100,000). The Canadian rate has mirrored the BC rate since at least 1994. Increases in the mid to late 1990s, seen in many developed countries, were attributed to more accessible chlamydia testing using urine and cervical PCR. This 'testing effect', however, no longer provides a reasonable explanation for the sustained increases seen throughout the world. It has been suggested that early diagnosis and treatment may actually interfere with the development of natural immunities increasing the pool of susceptible persons.



The gonorrhea rate for BC, on the other hand, decreased from 17.3 per 100,000 in 2002 to 16.3 per 100,000 in 2003 (normal-value test, $p=0.14$). This continues a downward trend that began in 1999 (21.4 per 100,000). At the same time, the Canadian gonorrhea rate has increased steadily from 17.6 in 1999 to 24.2 in 2003. BC saw no significant trends in age and gender, however the Northern Interior Health Service Delivery Area recorded a rate increase from 10.0 per 100,000 (2002) to 20.4 (2003).

epidemiology

In British Columbia, provincial law requires that certain communicable diseases be reported to the Medical Health Officer of the region by health care providers and laboratories. The main reportable STIs are gonorrhea, chlamydia, syphilis, HIV and AIDS. HIV infection became reportable, May 1, 2003.

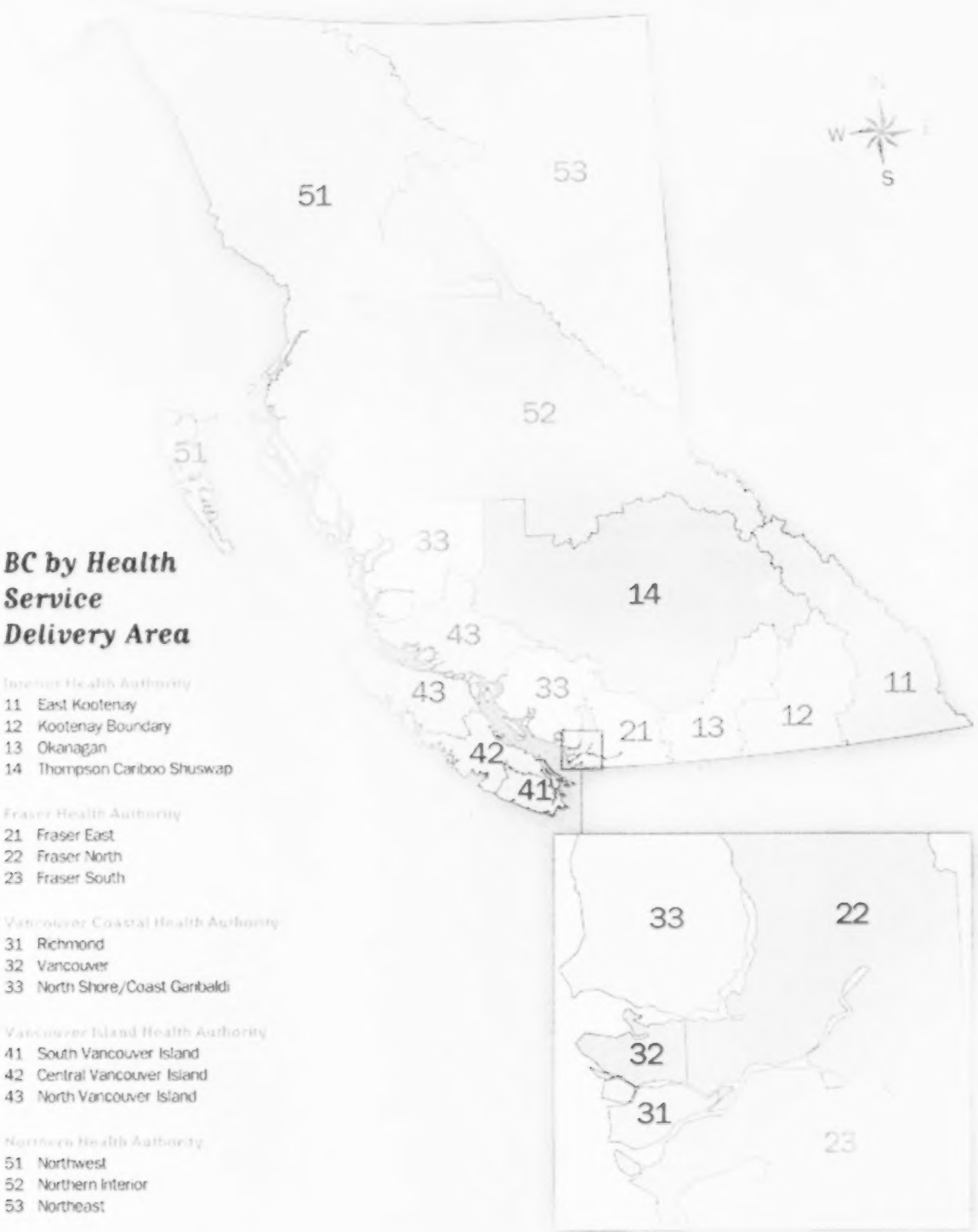
Mandatory reporting:

- Enables health care workers to follow up on reported infections to ensure adequate treatment and care is provided;
- Reduces the spread of infection through partner notification and other measures;
- Allows health care workers to monitor the incidence of the disease to assist with prevention strategies.

This reporting supplies the data for our epidemiology reports for these diseases.

For information on pelvic inflammatory disease, please refer to page 40.

BC by Health Service Delivery Area



Interior Health Authority

11 East Kootenay
12 Kootenay Boundary
13 Okanagan
14 Thompson Cariboo Shuswap

Fraser Health Authority

21 Fraser East
22 Fraser North
23 Fraser South

Vancouver Coastal Health Authority

31 Richmond
32 Vancouver
33 North Shore/Coast Garibaldi

Vancouver Island Health Authority

41 South Vancouver Island
42 Central Vancouver Island
43 North Vancouver Island

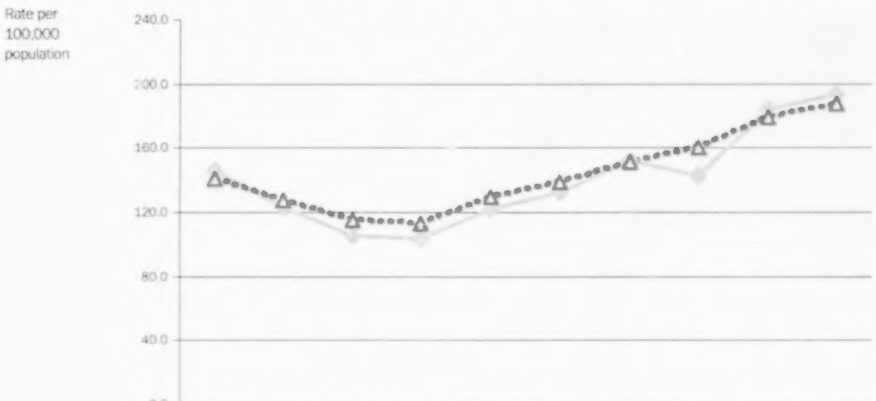
Northern Health Authority

51 Northwest
52 Northern Interior
53 Northeast

chlamydia

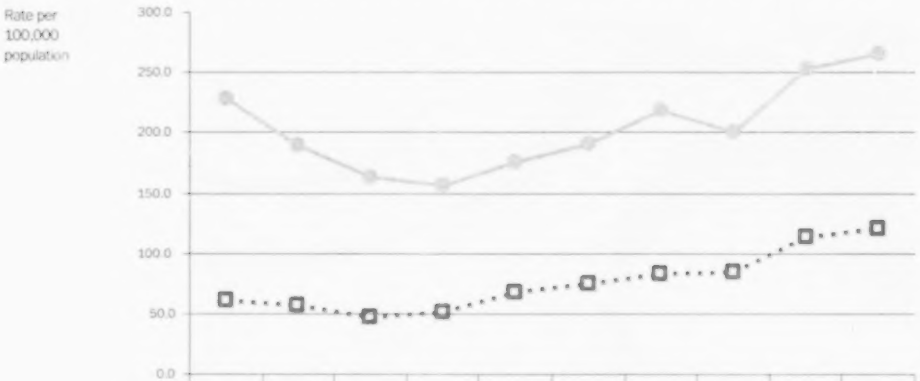
The BC rate per 100,000 population for reported cases of chlamydia genital infection increased from 183.9 in 2002 to 193.1 in 2003. The Canadian rate also increased slightly (See Graph 2.1). The Northwest Health Service Delivery Area (HSDA) had the highest provincial rate, 313.9 (See Graph 2.3). The rates increased for both genders and in most age groups (See Graph 2.4 and 2.5).

2.1 BC chlamydia disease case reports and rates • 1994 to 2003



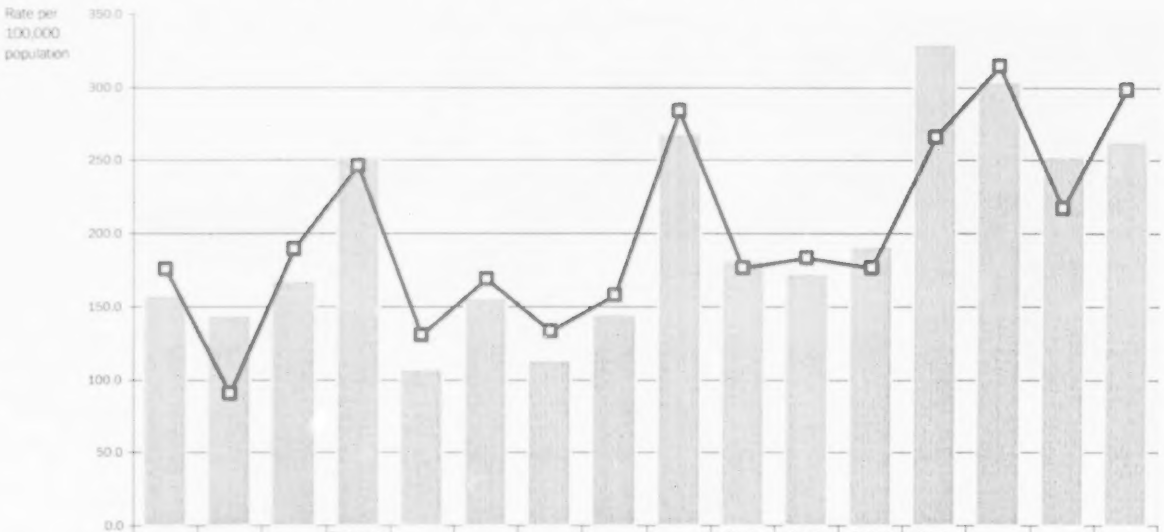
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Reports	5,366	4,660	4,116	4,116	4,876	5,352	6,163	5,858	7,614	8,073
BC Rate	145.7	123.1	106.0	103.9	122.0	132.9	151.8	142.8	183.9	193.1
Canadian Rate	141.0	126.8	114.8	112.7	128.8	138.2	150.9	160.7	179.3	186.9

2.2 BC chlamydia disease case reports and rates by gender • 1994 to 2003



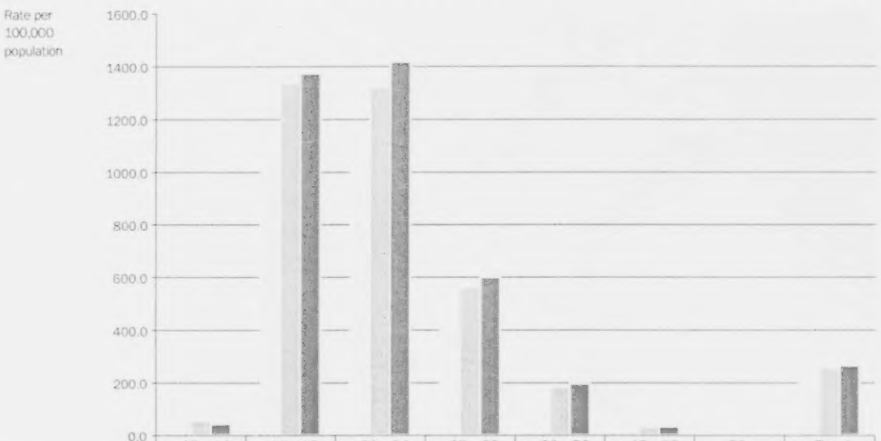
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Reports – Female	4,215	3,602	3,191	3,110	3,515	3,866	4,478	4,141	5,290	5,584
Reports – Male	1,126	1,057	917	1,002	1,360	1,485	1,682	1,717	2,323	2,488
Rate – Female	228.2	189.7	163.8	156.4	175.0	190.7	219.1	200.4	253.3	264.8
Rate – Male	61.4	56.1	47.4	50.8	68.4	74.2	83.4	84.4	113.1	120.1

2.3 BC chlamydia disease case reports and rates by health service delivery area • 2002 and 2003



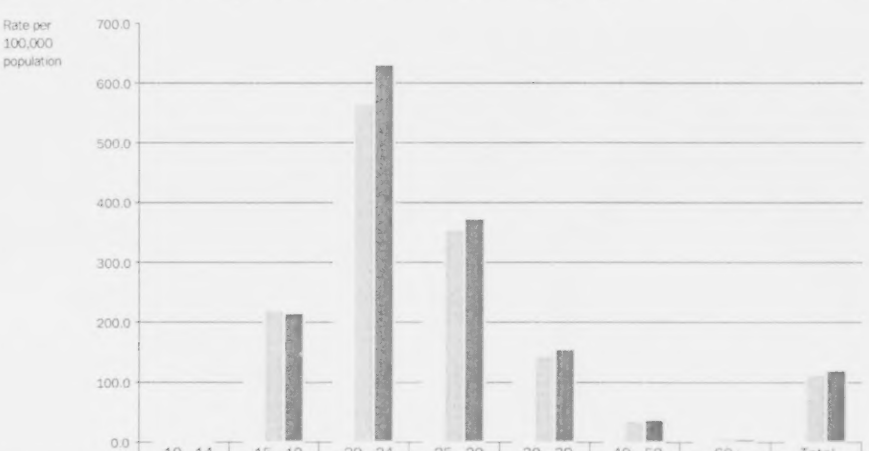
	East Kootenay	Kootenay Boundary	Okanagan	Thompson Cariboo Shuswap	Fraser East	Fraser North	Fraser South	Richmond	Vancouver	North Shore/Coast Garibaldi	South Vancouver Island	Central Vancouver Island	North Vancouver Island	Northwest	Northern Interior	Northeast
Reports 2003	141	72	594	534	336	946	832	278	1693	478	625	426	304	266	330	196
Rate 2002	157.2	143.9	167.7	252.1	107.6	155.6	112.9	145.1	268.1	181.5	172.5	191.7	329.8	304.3	253.0	263.5
Rate 2003	175.3	90.6	189.2	246.1	130.4	168.6	133.0	157.5	283.5	176.7	183.0	176.2	265.6	313.9	217.2	298.4

2.4 BC female chlamydia disease rates by age • 2001/2002/2003



	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total
2001 Rate – Female	40.7	1,041.7	1,051.0	412.7	151.6	30.5	0.8	200.4
2002 Rate – Female	55.4	1,333.3	1,318.7	561.9	182.5	30.9	1.3	253.3
* 2003 Rate – Female	43.6	1,373.8	1,417.5	599.5	196.2	32.3	1.5	264.8

2.5 BC male chlamydia disease rates by age • 2001/2002/2003



	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total
2001 Rate – Male	1.5	157.1	453.6	251.0	100.9	26.2	2.5	84.4
2002 Rate – Male	0.7	219.7	565.2	354.0	144.1	36.3	6.3	113.1
* 2003 Rate – Male	0.7	215.3	630.6	372.7	155.3	37.4	6.1	120.1

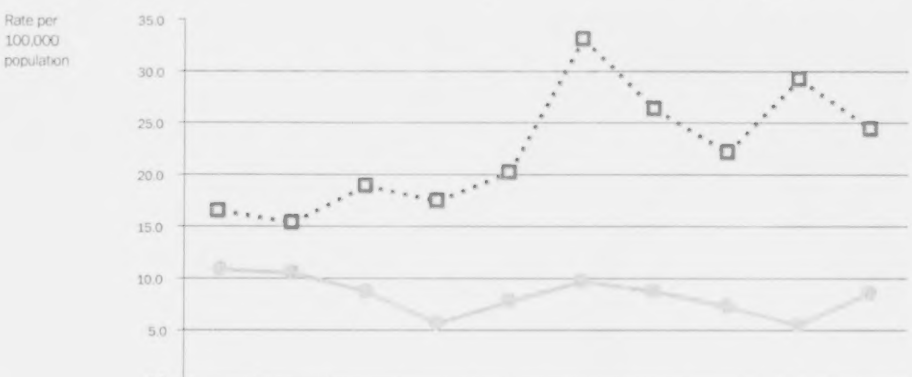
gonorrhea

The overall gonorrhea rate for BC decreased from 17.2 in 2002 to 16.4 per 100,000 in 2003, (See Graph 3.1). However, the female rate increased from 5.5 to 8.5 (54%) (See Graph 3.2) and the rates in both genders for 15-19 and 20-24 year olds increased significantly (See Graphs 3.4 and 3.5). The rate in 20-24 year old females more than doubled from 19.4 to 39.4. This increase in young female gonorrhea cases was seen in every Health Authority and was predominantly cervical infection. Northern Interior Health Service Delivery Area (HSDA) recorded the highest rate increase over 2002, from 10.0 to 20.4 (See Graph 3.3).

3.1 BC gonorrhea disease case reports and rates • 1994 to 2003

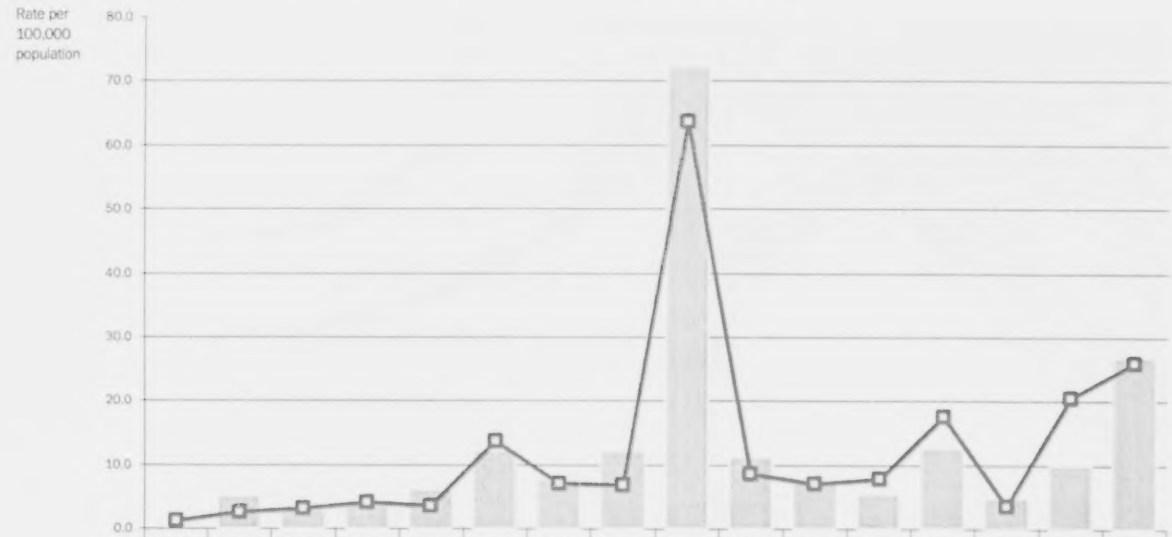
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Reports	504	492	534	456	558	859	707	600	714	684
BC Rate	13.7	13.0	13.8	11.5	14.0	21.3	17.4	14.6	17.2	16.4
Canadian Rate	21.1	19.3	16.8	14.9	16.4	17.6	20.1	21.6	23.0	24.2

3.2 BC gonorrhea disease case reports and rates by gender • 1994 to 2003



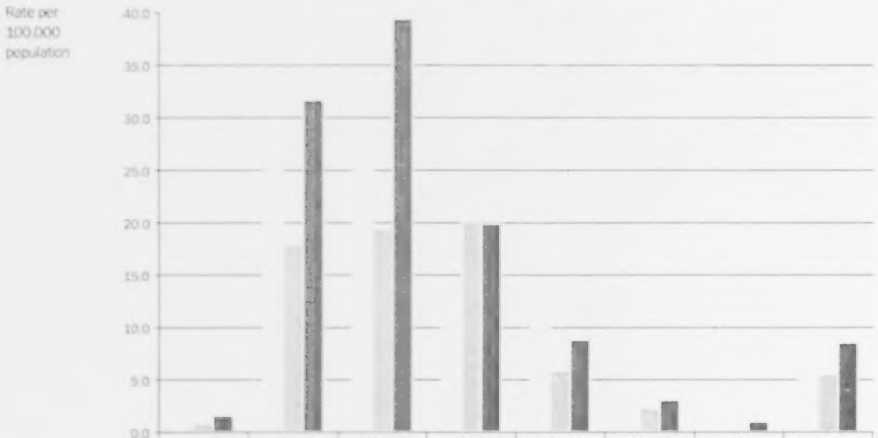
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Reports – Female	200	199	170	112	155	197	177	149	115	179
Reports – Male	303	290	364	343	402	661	529	451	599	504
Rate – Female	10.8	10.5	8.7	5.6	7.7	9.7	8.7	7.2	5.5	8.5
Rate – Male	16.5	15.4	18.8	17.4	20.2	33.0	26.2	22.2	29.2	24.3

3.3 BC gonorrhea disease case reports and rates by health service delivery area • 2002 and 2003



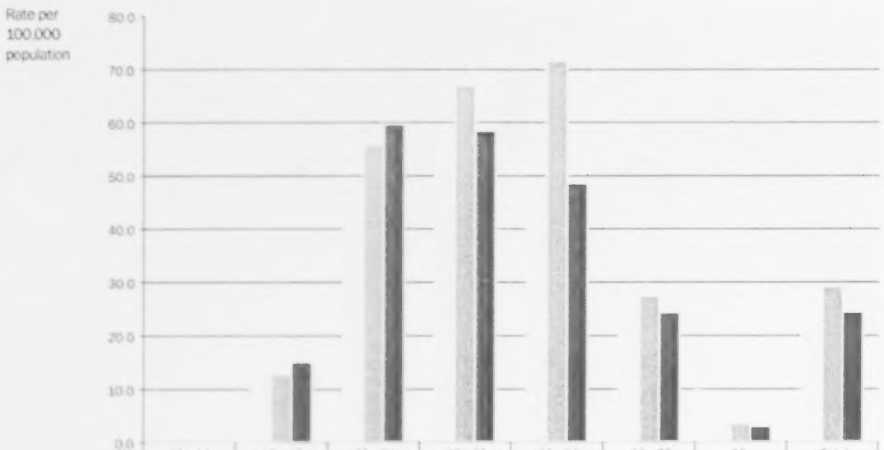
	East Kootenay	Kootenay Boundary	Okanagan	Thompson Cariboo Shuswap	Fraser East	Fraser North	Fraser South	Richmond	Vancouver	North Shore/Coast Garibaldi	South Vancouver Island	Central Vancouver Island	North Vancouver Island	Northwest	Northern Interior	Northeast
Reports 2003	1	2	10	9	9	77	44	12	380	23	24	19	20	3	31	17
Rate 2002	0.0	5.0	2.9	3.7	6.0	12.1	7.7	12.0	72.2	11.2	7.2	5.4	12.6	4.8	10.0	26.8
Rate 2003	1.2	2.5	3.2	4.1	3.5	13.7	7.0	6.8	63.6	8.5	7.0	7.9	17.5	3.5	20.4	25.9

3.4 BC female gonorrhea disease rates by age • 2001/2002/2003



	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total
2001 Rate – Female	1.6	26.3	28.8	11.1	10.7	3.5	0.5	7.2
◦ 2002 Rate – Female	0.8	17.9	19.4	20.1	5.9	2.3	0.3	5.5
• 2003 Rate – Female	1.6	31.7	39.4	19.9	8.8	3.0	1.0	8.5

3.5 BC male gonorrhea disease rates by age • 2001/2002/2003

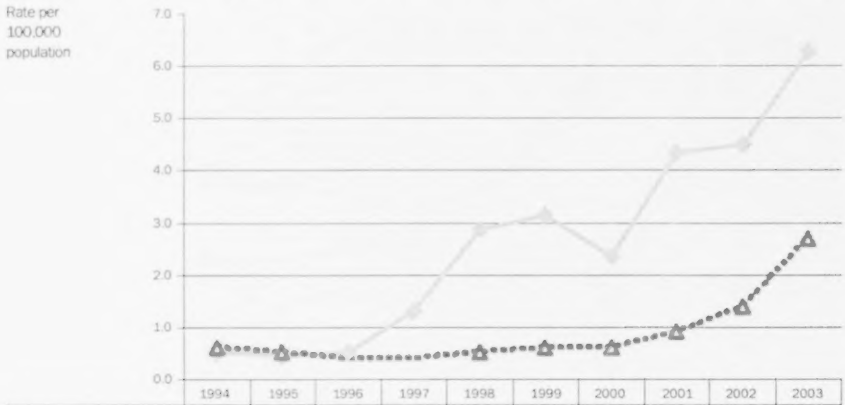


	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total
2001 Rate – Male	0.0	12.7	41.7	51.5	45.9	23.3	4.6	22.2
◦ 2002 Rate – Male	0.0	12.7	55.7	67.0	71.6	27.4	3.6	29.2
• 2003 Rate – Male	0.0	15.0	59.6	58.3	48.5	24.3	2.9	24.3

infectious syphilis

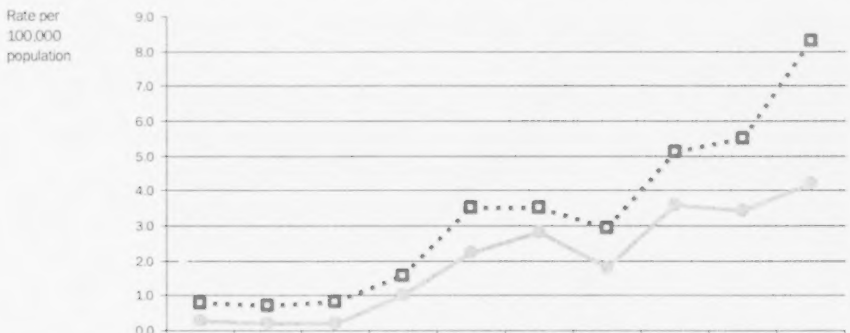
BC's infectious syphilis outbreak continued to grow. Compared to 2002, the number of BC cases increased from 186 to 262, and the provincial rate from 4.5 to 6.3 per 100,000. The Canadian rate increased significantly as well, from 1.4 to 2.7 (See Graph 4.1). The rate in males increased much more dramatically than the rate in females, reflecting the rapidly spreading outbreak in the gay community (See Graph 4.2). About half of all new syphilis cases are currently being diagnosed in gay men, compared to 10-20% in previous years (See Graph 4.4). Up to half of all new male cases are also HIV-infected. For males, the 30-39 year age group saw the biggest rate increase (from 13.0 to 20.9) (See Graph 4.6). The outbreak continues to be concentrated in Vancouver (See Graph 4.6).

4.1 BC infectious syphilis disease case reports and rates • 1994 to 2003



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Reports	19	17	20	51	115	127	96	178	186	262
BC Rate	0.5	0.4	0.5	1.3	2.9	3.2	2.4	4.3	4.5	6.3
Canadian Rate	0.6	0.5	0.4	0.4	0.5	0.6	0.6	0.9	1.4	2.7

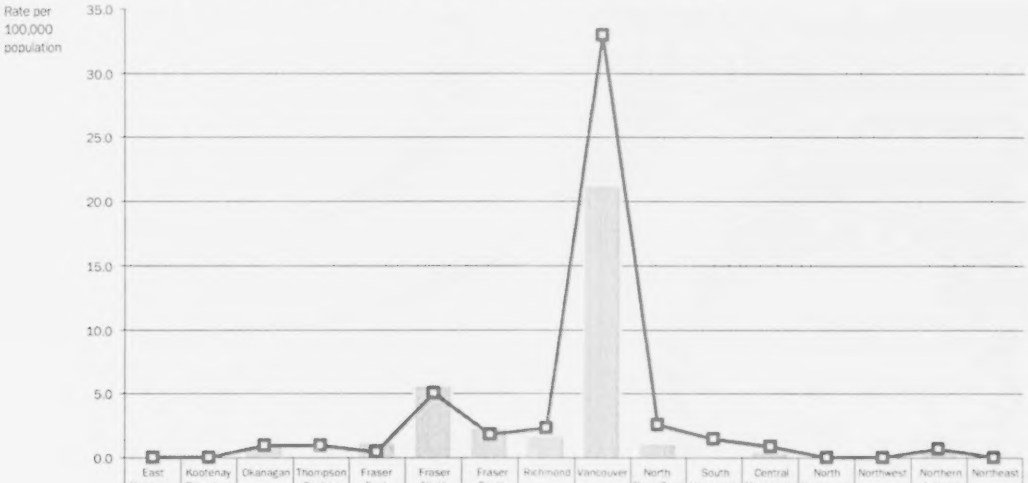
4.2 BC infectious syphilis disease case reports and rates by gender • 1994 to 2003



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Reports – Female	5	4	4	20	45	57	37	74	72	89
Reports – Male	14	13	16	31	70	70	59	104	113	172
Rate – Female	0.3	0.2	0.2	1.0	2.2	2.8	1.8	3.6	3.4	4.2
Rate – Male	0.8	0.7	0.8	1.6	3.5	3.5	2.9	5.1	5.5	8.3

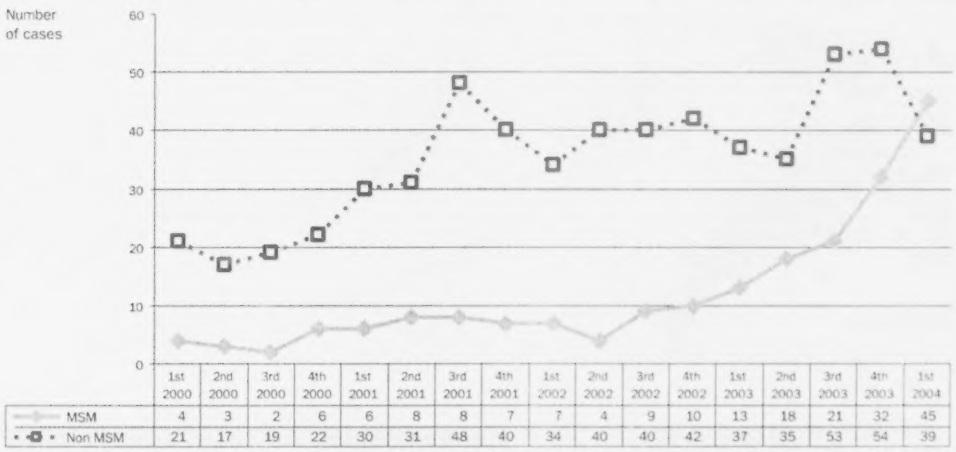
year

4.3 BC infectious syphilis disease case reports and rates by health sevice delivery area • 2002 and 2003



	East Kootenay	Kootenay Boundary	Okanagan	Thompson Cariboo Shuswap	Fraser East	Fraser North	Fraser South	Richmond	Vancouver	North Shore/Coast Garibaldi	South Vancouver Island	Central Vancouver Island	North Vancouver Island	Northwest	Northern Interior	Northeast
Reports 2003	0	0	3	2	1	28	11	4	197	7	5	2	0	0	1	0
Rate 2002	0.0	0.0	1.0	0.0	1.2	5.6	2.3	1.7	21.2	1.1	0.0	0.4	0.0	0.0	0.7	0.0
Rate 2003	0.0	0.0	1.0	0.9	0.4	5.0	1.8	2.3	33.0	2.6	1.5	0.8	0.0	0.0	0.7	0.0

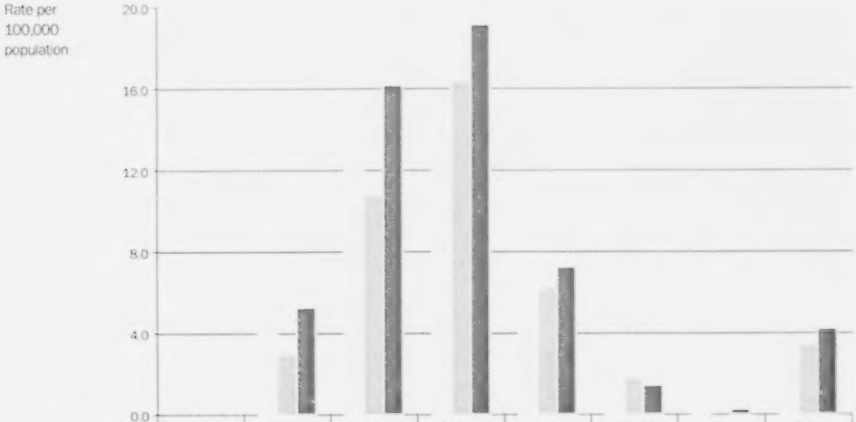
4.4 BC infectious syphilis by sexual preference • 2000 to 2004 (first quarter)



	1st 2000	2nd 2000	3rd 2000	4th 2000	1st 2001	2nd 2001	3rd 2001	4th 2001	1st 2002	2nd 2002	3rd 2002	4th 2002	1st 2003	2nd 2003	3rd 2003	4th 2003	1st 2004
MSM	4	3	2	6	6	8	8	7	7	4	9	10	13	18	21	32	45
Non MSM	21	17	19	22	30	31	48	40	34	40	40	42	37	35	53	54	39

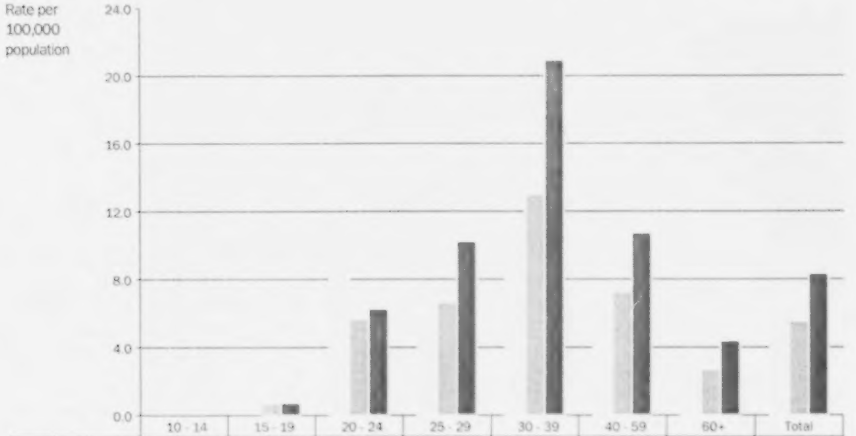
Note: 1st quarter 2004 is an estimate *MSM includes bisexual **Non MSM includes unspecified

4.5 BC female infectious syphilis disease rates by age • 2001/2002/2003



	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total
2001 Rate – Female	0.0	5.3	13.3	13.3	4.3	2.7	0.3	3.6
2002 Rate – Female	0.0	3.0	10.8	16.4	6.2	1.8	0.0	3.4
2003 Rate – Female	0.0	5.3	16.2	19.1	7.2	1.4	0.2	4.2

4.6 BC male infectious syphilis disease rates by age • 2001/2002/2003

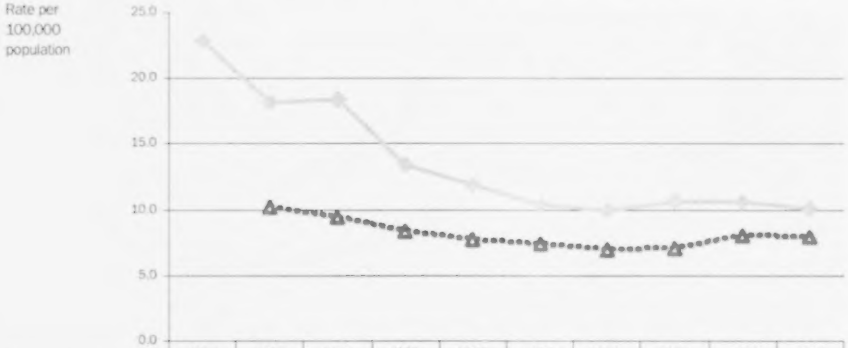


	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total
2001 Rate - Male	0.0	0.0	8.6	5.9	10.6	6.6	2.8	5.1
2002 Rate - Male	0.0	0.7	5.6	6.6	13.0	7.2	2.7	5.5
2003 Rate - Male	0.0	0.7	6.2	10.2	20.9	10.7	4.4	8.3

HIV

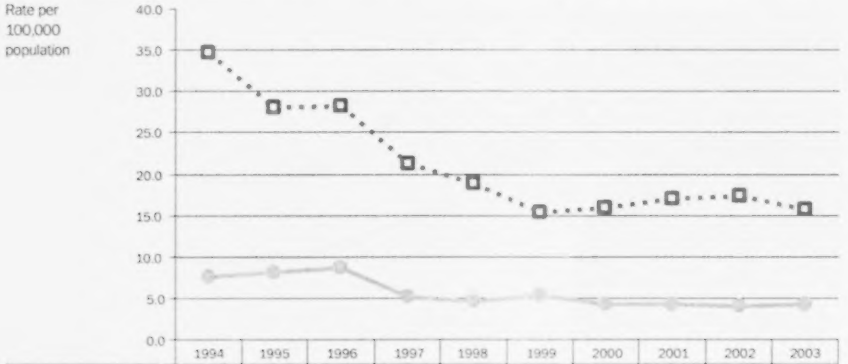
The rate of new positive HIV tests in BC decreased from 10.6 in 2002 to 10.0 in 2003. New cases decreased from 439 to 419 (See Graph 5.1). By risk category, the trend of increasing new positive tests in men who have sex with men (MSM) continued, with a very small increase (See Graph 5.4). The absolute numbers of new positive tests in MSM, injection drug users and heterosexuals have been adjusted upwards in this report following database review and reclassification. This, however, has not changed the trends in these groups. The increase in new positive tests in MSM corresponds to high numbers in the male age groups 30-39 and 40-59 (See Graph 5.6).

5.1 BC new positive HIV tests and rates • 1994 to 2003



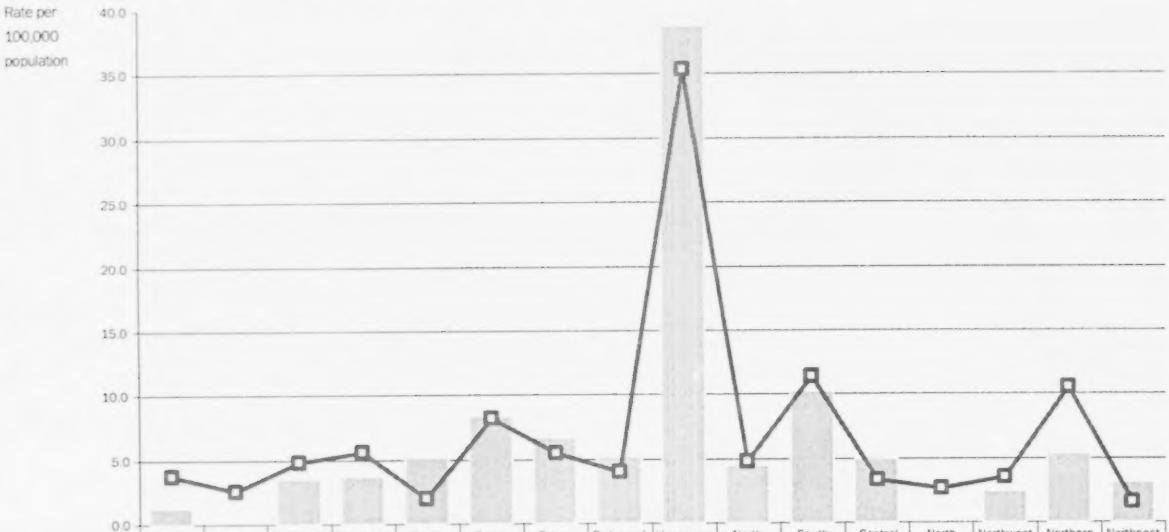
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Reports	840	688	714	531	477	418	406	436	439	419
BC Rate	22.8	18.2	18.4	13.4	11.9	10.4	10.0	10.6	10.6	10.0
Canadian Rate		10.2	9.4	8.4	7.7	7.4	6.9	7.0	8.0	7.8

5.2 BC new positive HIV tests and rates by gender • 1994 to 2003



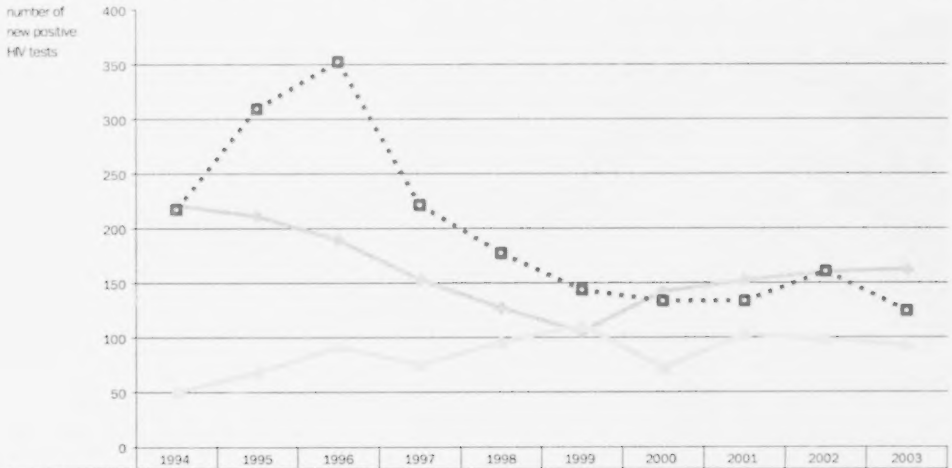
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Reports – Female	140	154	167	103	93	110	86	87	85	90
Reports – Male	637	530	544	418	375	307	320	344	354	325
Rate – Female	7.6	8.1	8.6	5.2	4.6	5.4	4.2	4.2	4.1	4.3
Rate – Male	34.7	28.1	28.1	21.2	18.9	15.3	15.9	16.9	17.2	15.7

5.3 BC new HIV positive tests and rates by health service delivery area • 2002 and 2003



	East Kootenay	Kootenay Boundary	Okanagan	Thompson Cariboo Shuswap	Fraser East	Fraser North	Fraser South	Richmond	Vancouver	North Shore/Coast Garibaldi	South Vancouver Island	Central Vancouver Island	North Vancouver Island	Northwest	Northern Interior	Northeast
Reports 2003	3	2	15	12	5	46	34	7	211	13	39	8	3	3	16	1
Rate 2002	1.3	0.0	3.5	3.7	5.2	8.3	6.7	5.1	38.7	4.5	10.2	5.0	0.0	2.4	5.3	3.2
Rate 2003	3.7	2.5	4.8	5.5	1.9	8.2	5.4	4.0	35.3	4.8	11.4	3.3	2.6	3.5	10.5	1.5

5.4 BC new positive HIV tests by risk category and year • 1994 to 2003



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
MSM	221	211	189	153	127	105	142	152	160	162
IDU	217	309	352	221	177	143	133	133	160	124
HET	50	68	91	75	96	111	72	103	98	93

The difference in the number of HIV cases by risk category between 2002 and 2003 as reported in the respective STD Annual Reports can be attributed to how the cases were counted according to risk.

2002 STD Annual Report:

MSM = MSM only (excludes MSM with multiple risk factors) + Bisexual males

IDU = IDU (excludes STW/IDU and WSW/IDU)

HET = Heterosexual Contact (excludes Patron of STW)

2003 STD Annual Report:

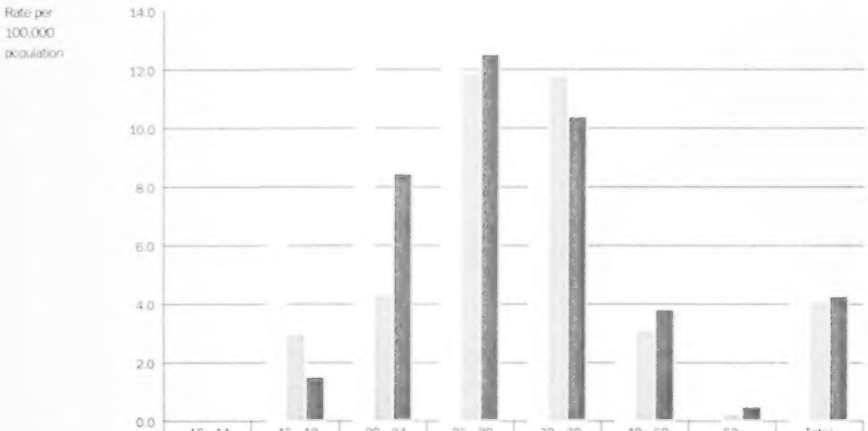
MSM = MSM only + MSM with multiple risk factors + Bisexual males + MSM/IDU

IDU = IDU + STW/IDU + WSW/IDU

HET = Heterosexual Contact + Patron of STW

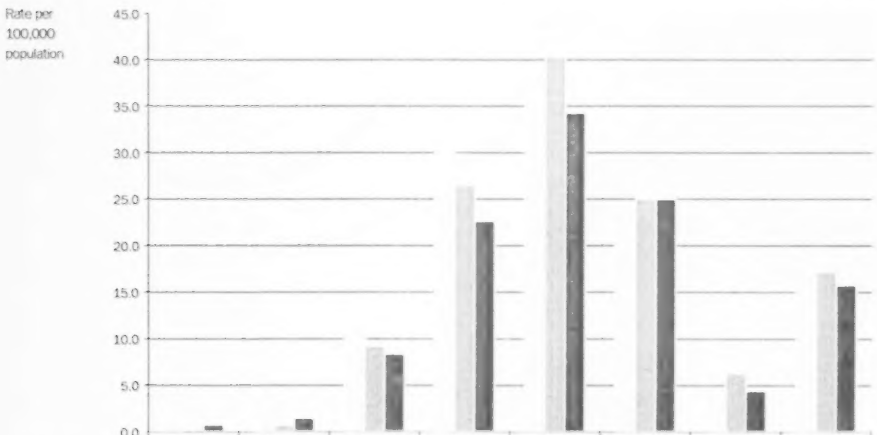
Note: IDU = injection drug user
MSM = men who have sex with men
STW = sex trade worker
WSW = women who have sex with women

5.5 BC female new positive HIV test rates by age • 2001/2002/2003



	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total
2001 Rate – Female	0.0	6.0	13.3	12.6	8.6	2.5	0.0	4.2
2002 Rate – Female	0.0	3.0	4.3	11.9	11.8	3.1	0.3	4.1
2003 Rate – Female	0.0	1.5	8.4	12.5	10.4	3.8	0.5	4.3

5.6 BC male new positive HIV test rates by age • 2001/2002/2003

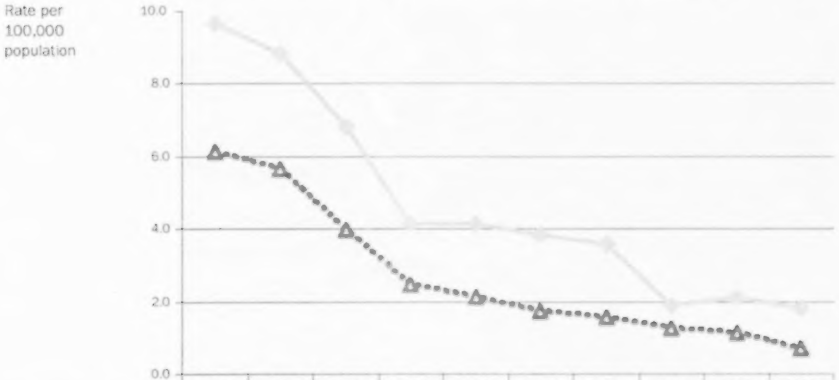


	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total
2001 Rate – Male	0.7	2.1	11.5	34.6	36.8	23.8	4.0	16.9
2002 Rate – Male	0.0	0.7	9.2	26.5	40.3	25.0	6.3	17.2
2003 Rate – Male	0.7	1.4	8.3	22.6	34.2	24.9	4.4	15.7

AIDS

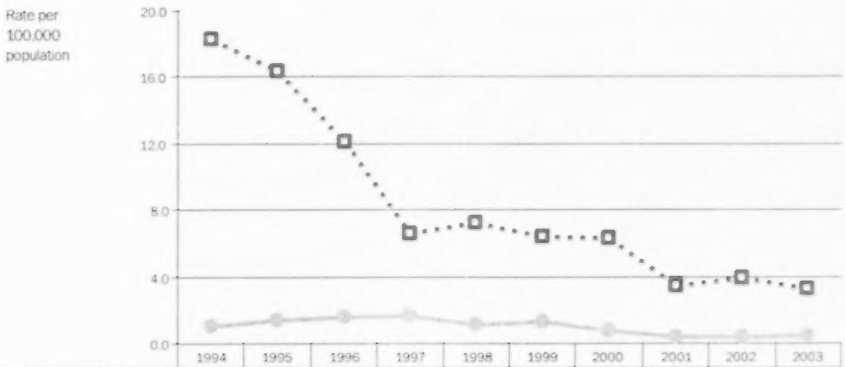
AIDS numbers and rates shown in our graphs are not necessarily complete due to late entry of new AIDS cases into the data system. We know, however, that AIDS cases and rates, for the province and in Canada, continued to decrease and there were no important trends by age, gender or geographic location.

6.1 BC AIDS disease case reports and rates • 1994 to 2003



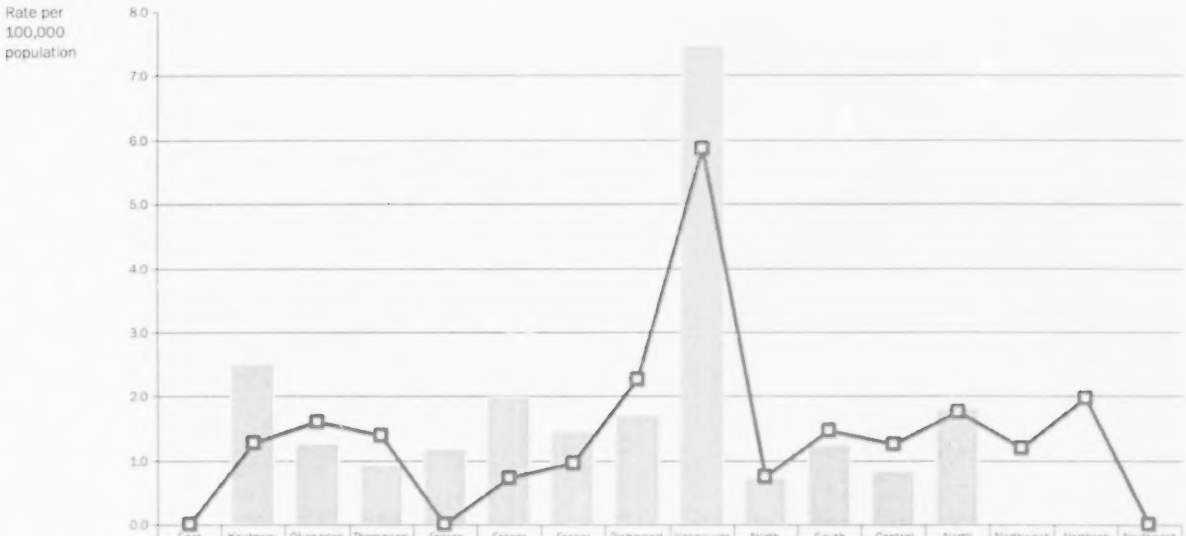
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Reports	355	335	264	163	166	154	145	77	88	75
BC Rate	9.6	8.9	6.8	4.1	4.2	3.8	3.6	1.9	2.1	1.8
Canadian Rate	6.1	5.6	4.0	2.4	2.1	1.7	1.5	1.2	1.1	0.7

6.2 BC AIDS disease case reports and rates by gender • 1994 to 2003



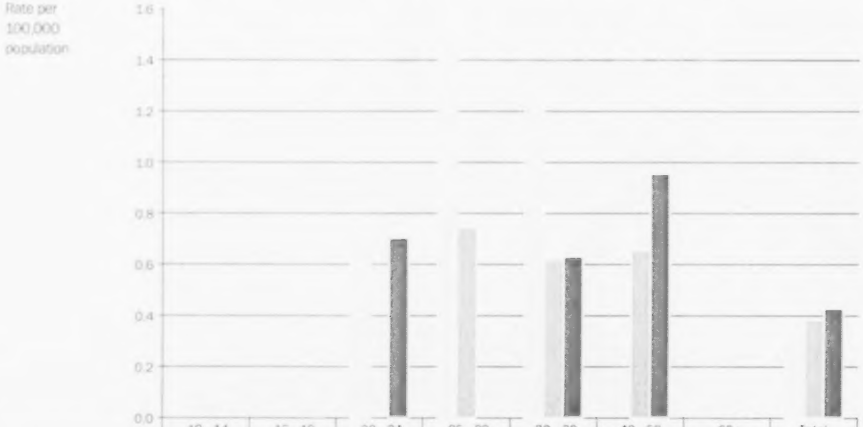
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Reports – Female	19	26	30	33	23	26	16	7	8	9
Reports – Male	335	308	233	129	143	127	127	70	79	66
Rate – Female	1.0	1.4	1.5	1.7	1.1	1.3	0.8	0.3	0.4	0.4
Rate – Male	18.3	16.3	12.0	6.5	7.2	6.3	6.3	3.4	3.8	3.2

6.3 BC AIDS disease case reports and rates by health service delivery area • 2002 and 2003



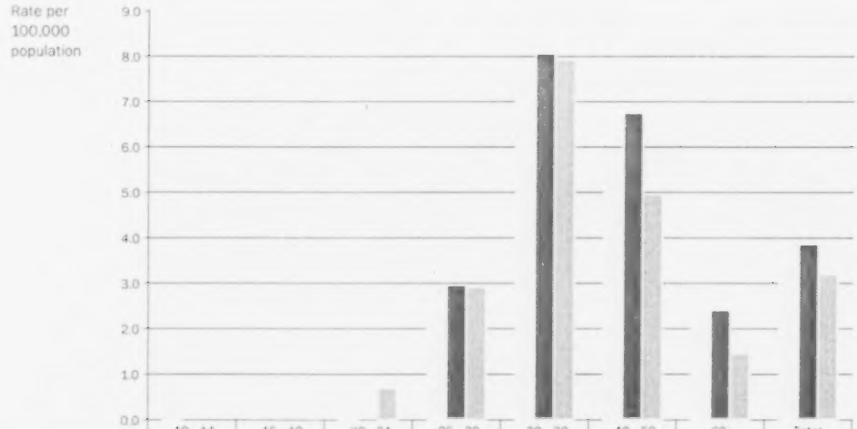
	East Kootenay	Kootenay Boundary	Okanagan	Thompson Cariboo Shuswap	Fraser East	Fraser North	Fraser South	Richmond	Vancouver	North Shore/Coast Garibaldi	South Vancouver Island	Central Vancouver Island	North Vancouver Island	Northwest	Northern Interior	Northeast
Reports 2003	0	1	5	3	0	4	6	4	35	2	5	3	2	1	3	0
Rate 2002	0.0	2.5	1.3	0.9	1.2	2.0	1.5	1.7	7.5	0.7	1.2	0.8	1.8	0.0	0.0	0.0
Rate 2003	0.0	1.3	1.6	1.4	0.0	0.7	1.0	2.3	5.9	0.7	1.5	1.2	1.7	1.2	2.0	0.0

6.4 BC female AIDS disease rates by age • 2001/2002/2003



	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total
2001 Rate – Female	0.0	0.0	0.7	1.5	1.2	0.0	0.0	0.3
2002 Rate – Female	0.0	0.0	0.0	0.7	0.6	0.7	0.0	0.4
* 2003 Rate – Female	0.0	0.0	0.7	0.0	0.6	1.0	0.0	0.4

6.5 BC male AIDS disease rates by age • 2001/2002/2003

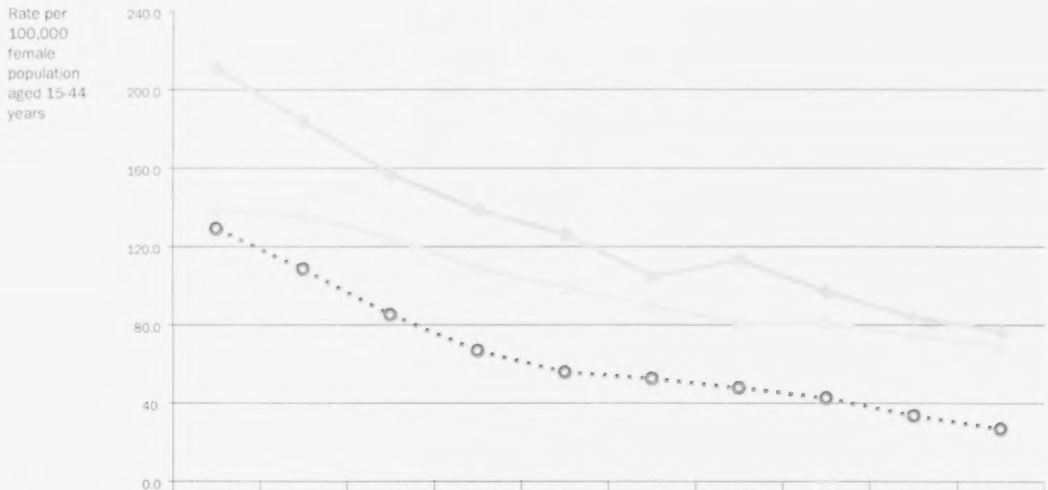


	10 - 14	15 - 19	20 - 24	25 - 29	30 - 39	40 - 59	60+	Total
2001 Rate – Male	0.7	0.0	0.7	2.2	7.0	5.7	2.2	3.4
* 2002 Rate – Male	0.0	0.0	0.0	2.9	8.1	6.7	2.4	3.8
2003 Rate – Male	0.0	0.0	0.7	2.9	7.9	5.0	1.5	3.2

PID

Ectopic pregnancies, diagnoses of tubal infertility and hospitalized cases of pelvic inflammatory disease (PID) all continued their downward trends. PID is a serious complication of sexually transmitted infections; and ectopic pregnancy and tubal infertility are long term complications of STIs in women.

7.1 Pelvic inflammatory disease, ectopic pregnancy, and tubal infertility • 1993 to 2002

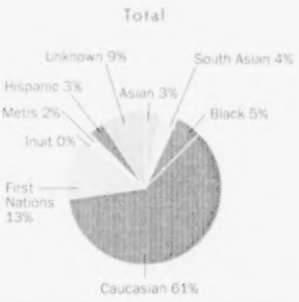


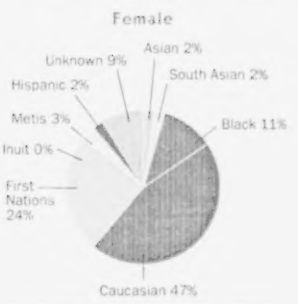
	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
PID Cases	1,742	1,557	1,361	1,235	1,142	948	1,024	875	760	695
Ectopic Cases	1,143	1,153	1,080	970	900	811	732	733	675	626
Tubal Cases	1,066	918	738	594	504	475	432	384	303	243
PID Rate	210.8	183.6	156.8	138.5	126.1	104.6	113.0	96.7	84.0	76.5
Ectopic Rate	138.3	136.0	124.4	108.8	99.4	89.5	81.0	80.8	74.5	68.9
Tubal Rate	129.0	108.3	85.0	66.6	55.6	52.4	47.7	42.5	33.5	26.8

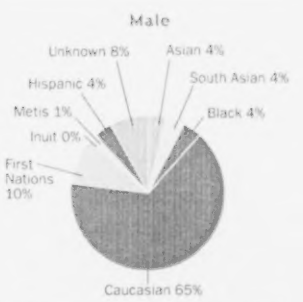
ethnicity

In BC, HIV and infectious syphilis continue to disproportionately affect First Nations, especially women.

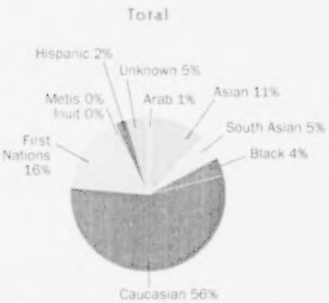
8.1 BC new HIV positive tests by ethnicity • 2003

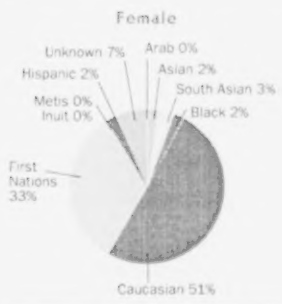


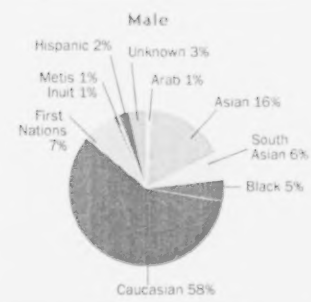




8.2 BC infectious syphilis reports by ethnicity • 2003







contact information

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STD/AIDS Resource Centre: 604-660-2090

STD/AIDS Control Education: 604-660-6220 or 604-660-0556

Chee Mamuk Program: 604-660-1673

HIV Surveillance: 604-775-2911

AIDS Case Reporting: 604-775-2911

West 12th STD Clinic: 604-660-6161

Bute Street STD Clinic: 604-660-7949

Powell Street Outreach Office: 604-660-9695

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